# PA17-2007: QUALAQUIN REQUEST

**RI MEDICAL ASSISTANCE PROGRAM**
**PRIOR AUTHORIZATION REQUEST FORM**

**FAX TO:**
**DEPARTMENT OF HUMAN SERVICES**
**ATTN: PHARMACIST**
**401-462-6336**

CLIENT NAME _____ DOB: __/___/_____ MEDICAID ID CARD NUMBER: / / / / / / / / / /

PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____

PRESCRIBER OFFICE ADDRESS: _____

_____

OFFICE PHONE NUMBER ( ) _____- _____

REQUESTER NAME: _____ RN /MD /R.PH / _____

PHONE NUMBER ( ) _____-_____ FAX NUMBER ( )_____-_____

DRUG REQUESTED _____ STRENGTH _____

REQUEST TYPE (CIRCLE ONE) INITIAL / REAUTHORIZATION START DATE _____ UNITS / RX _____

DURATION OF THERAPY: 1 3 6 9 12 MONTHS (CIRCLE ONE) DOSING FREQUENCY: _____

---

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS
www.dhs.state.ri.us/dhs/heacre/provsvcs/mpharpa.htm

Does the patient have a diagnosis of malaria? Yes/No

**COMMENTS:**

**PRESCRIBER SIGNATURE** _____ **DATE** _____

*By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.*

**PA #** _____ **APPROVED**_____
**DENIED** _____
**PENDING ADDITIONAL INFORMATION**_____
**DATE /TIME OF RECEIPT** _____
**DATE/TIME RESPONSE** _____
**REVIEWER** _____
**COMMENTS:**

**DHS RI PRIOR AUTHORIZATION**
**FAX NUMBER 401-462-6336**

**CONTACT EDS CUSTOMER SERVICE FOR QUESTIONS:**
**401-784-8100**

Revised 7.31.2009